

Development of a Group Treatment for Enhancing Motivation to Change PTSD Symptoms

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Readiness to change, particularly ambivalence or lack of awareness about the need to change, is a modifiable variable that may underlie poor posttreatment outcome found in some studies of combat veterans with PTSD. The authors describe the PTSD Motivation Enhancement (ME) Group, a manualized brief treatment that is conceptually based on the Stages of Change and draws on interventions from the literature on Motivational Interviewing techniques. The PTSD ME Group targets any PTSD symptom or related problem behavior (e.g., anger, hypervigilance, owning weapons, depression, and substance use) that patients report ambivalence about changing or feel no need to change. The goal of the group is to help patients make decisions about the need to change any behaviors, coping styles, or beliefs not previously recognized as problematic. Although definitive statements about the effectiveness of the group await controlled trials, initial findings indicate that patients are responding to the group as predicted. Further research will test the hypothesis that addition of the PTSD ME Group to a PTSD treatment program is associated with better learning, practice, and implementation of coping skills, which, in turn, should predict better posttreatment functioning.

PSYCHOSOCIAL TREATMENTS for combat-related post-traumatic stress disorder (PTSD) can be efficacious in clinical trials of specific interventions (Foa, Keane, & Friedman, 2000; Sherman, 1998). However, recent findings have suggested that PTSD treatment programs may have a limited impact on symptom reduction for Vietnam veterans with long-standing PTSD (Fontana & Rosenheck, 1997; Johnson et al., 1996). Because of this persistence of symptoms, combat-related PTSD has been labeled a chronic disorder for this population (Bremner, Southwick, Darnell, & Charney, 1996; Zlotnick et al., 1999).

One unexplored factor that may be associated with PTSD chronicity and poor response to treatment is patient ambivalence about the need to change (Murphy, Cameron, Sharp, & Ramirez, 1999; Newman, 1994; Prochaska & DiClemente, 1983). Because trauma victims with PTSD are often distrustful, working with them can be a challenge (McBride & Markos, 1994; Zaslov, 1994). In our experience in the VA PTSD treatment system, treatment providers have experienced some patients as resistant, hostile to treatment staff, and externalizing with regard to their difficulties. In the past, some have viewed "treatment resistance" as a personality or "attitude" problem inherent among veterans with PTSD, with the consequence that programs implemented therapeutic commu-

nity techniques that included confrontation or "attack therapy" as the preferred way of dealing with the perceived resistance. Such confrontational approaches, which have been applied with substance abusers, batterers, and other populations, conflict with the need to establish empathy and a climate of safety within which trauma issues can be addressed (C. Murphy & Baxter, 1997; Newman). In our view, it is critical to avoid blaming trauma survivors for difficulties with distrust and avoidance, both symptoms of PTSD.

Despite their negative consequences, trauma-based perceptions and strategies for coping with safety and interpersonal interactions often feel "right" or appropriate to both civilian and military trauma victims. Trauma survivors with PTSD often find it difficult to view their trauma-based behaviors and cognitions as problematic. In our experience implementing coping-focused treatments such as symptom skills management, conflict resolution training, emotion management, and cognitive restructuring, veterans with PTSD often seemed reluctant to use new skills or, more importantly, to give up old ways of coping. For example, PTSD patients may view isolation as an effective way of reducing distress rather than as a problem. Anger is a particularly common and insidious example of how patients with PTSD can externalize and minimize a symptom (Chemtob, Novaco, Hamada, & Gross, 1997; Novaco & Chemtob, 1998). Many treatment-seeking combat veterans are tired of being angry, and tired of the consequences of their anger, such as physical damage as a result of violence, family problems, and legal

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problems. Although such patients come into treatment reporting "anger problems," their view of the problem is often different from the therapist's view. The therapist may assume that patients understand their anger-related behavior as an overreaction to a current situation based on past experiences. In contrast, the patient often firmly sees their anger as a normal response to any interaction with what they view as a hostile, provocative world full of people who are careless, unaware of danger, uncaring, and threatening (DiGiuseppe, 1995; DiGiuseppe, Tafrate, & Eckhardt, 1994). We have frequently heard PTSD-diagnosed veterans say that "the average guy is stupid" with regard to trust or potential harm in the day-to-day world.

Treatment staff and patients are often unaware of how their differing assumptions impact the therapeutic alliance. Treatment providers often label patients' lack of practice or use of coping tools as "resistance" or "symptom chronicity," attributing this to a personality trait of "denial" or oppositionality, "bad attitude," or a general fear of change. Even if therapists and clients agree on what problems the client is facing, they may have two opposite views as to the cause of the problems and what needs to be changed (Newman, 1994).

A Stages-of-Change Approach to PTSD Symptoms and Related Problems

We therefore began to consider resistance, ambivalence, and symptom chronicity within the Stages of Change in the Transtheoretical Model (Prochaska & DiClemente, 1983) and William Miller's Motivational Interviewing approach (Miller, 1985; Miller & Rollnick, 1991). The Transtheoretical Model assumes that modifiable beliefs about the need to change, rather than personality traits of "denial" or negative attitude, underlie the behavioral change process and response to treatment. One component of the Transtheoretical Model, the Stages of Change, describes five stages associated with different beliefs about the need to change and actions toward change, including lack of awareness that a problem exists (*precontemplation*), ambivalence about the need to change (*contemplation*), initial steps in preparing for change (*preparation*), engagement in efforts to change (*action*), and maintaining change (*maintenance*). A key assumption in the Transtheoretical Model is that different psychoeducational or therapeutic techniques are needed at each stage to help individuals resolve questions about the need or ability to change that behavior and move to the next stage. The model has been applied largely to smoking and substance abuse (Prochaska, DiClemente, & Norcross, 1992) but has been extended to a wide variety of patient populations (Rosen, 2000), including male batterers (Daniels & Murphy, 1997; C. Murphy & Baxter, 1997; Levesque, Gelles, & Velicer, 2000). Readiness-to-

change variables have been found to predict psychotherapy dropout (Brogan, Prochaska, & Prochaska, 1999; Smith, Subich, & Kalodner, 1995) and substance use (Belding, Iguchi, & Lamb, 1997; Heather, Rollnick, & Bell, 1993). Motivation enhancement interventions based on the Transtheoretical Model have been effective in reducing HIV risk behaviors (Carey et al., 1997) and alcohol use by college students (Borsani & Carey, 2000), problem drinkers (Miller, Benefield, & Tonigan, 1993), and alcoholics high in anger (Project Match Research Group, 1998).

Studies of traumatized populations have examined beliefs about the need to change unspecified "problems" among adult survivors of child abuse (Koraleski & Larson, 1997) and relationship behaviors among battered women (Feuer, Meade, Milstead, & Resick, 1999; Wells, 1998). Little is known about readiness to change the wide range of specific PTSD symptoms and related problem behaviors among combat veterans. Rosen et al. (2001) assessed readiness for change for two different problems, alcohol abuse and anger control, among male combat veterans entering residential PTSD treatment. Patients varied in their readiness to address these two problems, and could be categorized into subtypes consistent with the Transtheoretical Model. For both alcohol abuse and anger management, patients in the action/maintenance stage for that problem reported more frequent use of change strategies than did patients in the precontemplation stage. The relationship of readiness to change PTSD symptoms to treatment engagement and outcome is unknown.

We have adapted the Stages of Change (see Table 1) for conceptualizing readiness to change PTSD symptoms and related behaviors and cognitions. This model includes identification of the specific intervention necessary to move an individual up to the next stage of readiness to change, or belief about the need to change. We have emphasized the conceptualization of the cognitive state of an individual in the form of a question that is unique to each stage, with particular interventions best suited for helping an individual answer that question (Miller, 1985; Miller & Rollnick, 1991; Prochaska & DiClemente, 1983). For any particular problem behavior, individuals in the first stage, precontemplation, do not believe that they have a problem ("What problem?"). Here, for example, education about what constitutes a problem (e.g., hypervigilance, substance abuse, or PTSD in general) helps individuals move to the next stage, contemplation. In this stage, individuals may begin to consider the need for change ("Do I need to change?"). Decisional balance techniques and comparison of one's behavior to population norms are used to help resolve ambivalence about the need to change. Once convinced of the need to change, individuals still may be doubtful or ambivalent about their ability to make the necessary changes ("Can I change?"). Peer modeling and mastery

Table 1
Stage of Change Model for PTSD

Stage	Description	Question	Intervention
Precontemplation	Person is not considering or does not want to change a particular behavior	What problem?	<ul style="list-style-type: none"> • Education about PTSD <i>in general</i>
Contemplation	Person is certainly thinking about changing a behavior	Do I need to change?	<ul style="list-style-type: none"> • Pros and cons • Comparison to norms
Preparation	Person is seriously considering and planning to change a behavior and has taken steps toward change	Can I change?	<ul style="list-style-type: none"> • Education about how therapy works • Expose to successful peers • Mastery experiences
Action	Person actively doing things to change or modify behavior	How do I change?	<ul style="list-style-type: none"> • Skill building • Homework • Practice, role-play
Maintenance	Person continues to maintain behavioral change until it becomes permanent	How do I keep change?	<ul style="list-style-type: none"> • Lifestyle change • Continue support • Relapse prevention

Note. Adapted from Miller & Rollnick, 1991; and Prochaska, DiClemente, & Norcross, 1992.

PTSD Motivation Enhancement (ME) Group, in an uncontrolled clinical trial. During our implementation of the group, we collected preliminary data on the need for and potential value of the group, which we have submitted elsewhere but summarize in the Preliminary Findings section below. It is important to emphasize, however, that randomized control studies of the group have not been completed. Therefore, the present paper must be considered a report on a work in progress, and we focus here on the rationale and technique for implementing the PTSD ME Group.

The PTSD ME group is conceptually based on the Stages of Change and draws on interventions from the literature on Motivational Interviewing techniques (Miller, 1985; Miller & Rollnick, 1991). The goal of the group is to help patients make decisions about the need to change any PTSD-related behaviors, coping styles, or beliefs

experiences are helpful in this preparation stage in building self-efficacy and promoting hope for change. The final stages are action, in which individuals are actively making behavior changes, and maintenance, in which they are doing what is necessary to maintain the behavioral change. Skill-building, practice, reinforcement, and relapse prevention are best implemented in these latter stages.

In general, within the Motivational Interviewing and Stages of Change frameworks, "resistance" is a result of such factors as a lack of awareness of or sensitivity to negative consequences, the perception of problem behaviors or consequences as normative, and the presence of emotional, cognitive, or practical roadblocks to change. Regarding patients' perceptions about what is "normal," many treatment-seeking PTSD veterans grew up in families and neighborhoods where substance abuse, marital conflict, and aggressiveness were common. Even more frequently, upon their discharge from the military, veterans in PTSD treatment often report living substance-related lifestyles, where aggressiveness, emotional numbing, mistrust, and violence have been the norm.

Development of the PTSD Motivation Enhancement Group

As we began to reconceptualize our patients' difficulties in engagement in and utilization of treatment in the readiness-to-change model, we decided that there was an urgent clinical need to address patient ambivalence or lack of awareness of the need to change. Therefore, we developed and implemented a brief therapy group, the

not previously recognized as problematic in order to increase patient engagement in treatment and promote adaptive posttreatment coping. The seven-session group is designed to meet the needs of managed-care environments that require manualized brief treatments that have measurable outcomes with built-in program evaluation and assessment of patient satisfaction.

General Clinical Considerations

In implementing this intervention, group leaders should follow the overall approach recommended by Newman (1994) and Miller and colleagues (Miller, 1985; Miller & Rollnick, 1991): objective, nonconfrontational, and always using empathic listening techniques to address patients' responses, no matter how "oppositional" they might seem. Similar approaches have been advocated for treatment of anger (DiGiuseppe et al., 1994) and batterers (C. Murphy & Baxter, 1997). We have found that many clinicians, regardless of experience, have difficulty taking a nonconfrontational stance with provocative and externalizing patients. However, the basis for change is a therapeutic relationship or working alliance, best fostered by therapists using reflective techniques resulting in patients feeling understood, listened to, and more willing to trust (Horvath & Luborsky, 1993; Miller, 1985). Numerous studies of psychotherapy suggest that therapist empathy and client report of the working alliance are the best predictors of patient outcome (Horvath & Symonds, 1991; Miller et al., 1993).

A second general consideration in implementing the

PTSD ME Group is the importance of promoting interaction and participation and giving patients a sense of ownership of the process and their decision-making (Newman, 1994; Rosen & Sharp, 1998). For example, although the facilitator provides an overall structure to the discussion, patients are encouraged to verbalize their responses so that more active, insightful, or adept group members can serve as role models and facilitate observational learning. This approach creates an atmosphere of openness and helps prompt anxious or distrustful members to participate. This is particularly helpful in the PTSD ME Group, since the focus is on the often unpleasant task of discussing ambivalence or lack of awareness about the need to change, especially for problems that others may have been trying to get the patient to admit. Most important, patients are encouraged to use the process to draw their own conclusions about whether they need to change any particular behavior.

Regarding group size, in our experience the number of participants has been dictated by the needs of the treatment program in which the PTSD ME Group has been embedded. Because of this, we have run the group with anywhere from 4 to 40 participants. Although a larger number of patients enhances the benefits of group process described above, the ideal number of participants may be 8 to 15 using 90-minute sessions, which allows enough time for each participant to report on their progress in accomplishing the various tasks specific to the PTSD ME group.

Implementing the PTSD ME Group

General Structure

The group protocol consists of seven 90-minute group sessions: six sessions with four separate group modules (two modules are repeated) and a seventh session which is a repetition of the first group attended (see Table 2). This seventh "repeat" session was added because veterans can be disoriented during their first few days in a treatment program. To further accommodate the effects of rolling admissions and the extent of memory and attention deficit in this population, behavioral learning principles of repetition and rehearsal are used by reviewing the purpose, rationale, and format of the group for the first half of each group session. This review is accomplished by group leaders asking a series of questions of the group, usually with more experienced members answering, thereby educating and accu-

turing the newcomers. In this review period, time is given to individualized identification of problems that patients "might have." The second half of each session consists of discussion of the use of specific tools that will assist patients in deciding if problems that they might have are behaviors they need to change. Group leaders follow a treatment manual and make extensive use of a whiteboard and patient worksheets that are included in a patient workbook.

Form 1: A Worksheet for Decision Making About the Need to Change

A key part of the group is having patients generate a list of behaviors or beliefs that might be a problem for them. This process occurs in the first half of every session, following the general review of rationale and purpose. At that time, patients fill out a worksheet (Form 1) that is divided into three columns: DEFINITELY HAVE, MIGHT HAVE, or DEFINITELY DON'T HAVE. The MIGHT HAVE column is further divided into two categories: A PROBLEM YOU HAVE WONDERED IF YOU HAVE and A PROBLEM OTHERS SAY YOU HAVE (BUT YOU DISAGREE). We have defined "might have" problems in these two ways to elicit not only problem areas that they have considered as possibly needing change (contemplation stage), but also problems that they

Table 2
PTSD ME Group Session Outline

Session	Group Module	Tasks/Material Covered
Session 1	Group Overview	<ul style="list-style-type: none"> Review purpose and potential value of the group Generate list of problems "definitely have," "might have," "don't have"
Sessions 2 and 3	Comparison to the Average Guy	<ul style="list-style-type: none"> Review purpose and potential value of the group Generate list of problems "definitely have," "might have," "don't have" Patients compare their behavior to estimated age-appropriate norms in order to help them judge how problematic their behavior might be
Sessions 4 and 5	Pros and Cons	<ul style="list-style-type: none"> Review purpose and potential value of the group Generate list of problems "definitely have," "might have," "don't have" Decision balance techniques used to help patients decide about the need to change "might be a problem" behaviors which they agree they have, but are not sure are actually problematic
Session 6	Roadblocks	<ul style="list-style-type: none"> Review purpose and potential value of the group Generate list of problems "definitely have," "might have," "don't have" Identify fears, cognitive distortions, and stereotype beliefs that prevent problem identification
Session 7	In rolling admission context, patient repeats first group attended	

Problems You DEFINITELY <u>HAVE</u>	MIGHT HAVES		Problems You DEFINITELY <u>DON'T HAVE</u>
	Problems you <i>might</i> have: You have wondered if you have	Problems you <i>might</i> have: Problems other people say you have but you disagree	
<u>Patient A</u> Nightmares Depression Impatience	Trusting people Fly off the handle easily Problem with bosses Don't care what other people think	Restless Hard to get along with other people Emotionally cold	Drugs
<u>Patient B</u> Don't trust anyone Alcohol	Don't like too many people around me at one time	Been told I'm a mean person Always have to be in charge	Panic attacks

Figure 1. Examples of Form 1 worksheet responses for two patients participating in the PTSD ME Group.

might be unaware of or unwilling to change (precontemplation stage). The goal is for patients to eventually sort items listed under MIGHT HAVE INTO DEFINITELY HAVE OR DEFINITELY DON'T HAVE. At the end of every session, patients are given time to review their Form 1 and decide if they want to move any "might have" problems to one of the other columns. Examples of typical Form 1's completed by two outpatients at the beginning of their participation in the PTSD ME Group are presented in Figure 1.

Group Modules

In the first module (Session 1), Group Overview, the purpose and potential value of the group is reviewed in detail. The rationale for the group is presented in the following way. The group leader first asks, "In 25 words or less, what's the purpose of this group?" As described by the therapist, the best response is "to make decisions about problems you might have," which patients are usually able to articulate when the rationale is reviewed in later sessions. The therapist then prompts discussion of the question: "Why would we have a group about problems you 'might have,' and not about problems you know you have?" The therapist then asks, "If a patient does poorly after he leaves PTSD treatment, what reasons might he give?" Patients are then encouraged to describe attributions about continuation or return of PTSD-related problems and symptoms after treatment. The therapist summarizes participants' responses by characterizing the attributions as either external, usually blaming the treat-

ment providers ("the therapy was poor" or "the therapists were incompetent"), or internal (patient feels "broken" or unfixable). (We also point out some clear predictors of treatment success like medication compliance and following through with aftercare plans.) The therapist then offers a third possibility for treatment not working: that patients can be blindsided by an unrecognized problem. Being blindsided is described as an unacknowledged problem creating a downward spiral or sequence of other problems. The therapist then poses the question, "What are some examples of how a problem you don't think you have creates difficulties for you after treatment?" If needed, the therapist uses social isolation as an example, initially suggesting that isolation may be the first response to stress if it is still considered an adaptive coping response after treatment. The patients then describe, usually with a minimum of input from the therapist, how a tendency to isolate under stress may lead to other problems like disconnection from support and dwelling on past traumas, hurts, or injustices. This in turn could then pre-

cipitate excessive alcohol use, depression, increased hypervigilance, intrusive thoughts, anger, and loss of control.

At the end of the rationale review, the therapist points out that the ultimate goal of the group is to help patients to avoid getting blindsided by unacknowledged problems following discharge. The remainder of this session (the first half of all modules as described above) is spent reviewing the Form 1 worksheet and having the patients identify problems they "might have" on that form.

The second module, Comparison to the Average Guy (Sessions 2 and 3), is aimed at helping patients compare their behavior to estimated age-appropriate but non-PTSD norms in order to help them judge how problematic their behavior might be. Behaviors are categorized along a range including *average*, *moderate problem*, and *extreme problem*. Three dimensions are used to assess behavior at each of these levels: frequency, severity of consequences, and purpose. Group leaders guide members in analyzing what a particular behavior would look like at each of the three levels on each of the three dimensions. For example, if hypervigilance was the behavior selected, group leaders would elicit a description of normative levels of safety awareness, which might include checking to make sure doors are locked at night and installing motion-sensitive lights outside the house. At this level consequences are mild, such as cost of the lights. The purpose of the average level of safety awareness may be to feel reasonably safe. At the moderate problem level, behaviors might include frequently checking doors and windows at

night and installing more elaborate alarm systems, with consequences including more time and money invested. Here, the purpose begins to take on more of an anxiety-reduction role. At extreme levels of hypervigilance, behaviors may include checking the perimeter of the house all night, keeping a gun under the bed, and setting booby traps. Consequences are a great deal of time and energy spent and risk to children and others from the gun, with the purpose of the behavior more about survival and a feeling of "life or death." Seeing where their own behavior fits in this range of problems helps patients consider that they might have a problem they had not previously recognized. In one case, a patient spoke up after the hypervigilance example had been reviewed, and asked if there might be some harm in teaching his 9-year-old son to crawl under a wire without touching it, which he had been doing for some time. The ensuing discussion helped the patient consider that hypervigilance was a problem for him that needed to be addressed.

In the third module, Pros and Cons (Sessions 4 and 5), decision balance techniques are reviewed and practiced to help patients decide about the need to change "might have" behaviors—behaviors they agree that they engage in, but are not sure are actually problematic. In this simple but effective technique, patients weigh the advantages and disadvantages of various PTSD symptoms and related behaviors, such as gun ownership, continued alcohol use, and hypervigilance (e.g., "setting perimeters").

A case example involves a Vietnam veteran in an outpatient PTSD program who applied the decision balance tool to the problem of isolation. As a result of his wife's long-running complaint, he had listed isolation on his Form 1 in the column A PROBLEM OTHERS SAY I HAVE, BUT I DISAGREE. Under pros, the patient listed "Feel safer"; "When I want to do something, I can just do it"; "Don't have to deal with other people's problems"; and "Don't get into hassles with other people." The cons included "Distant from children"; "I get depressed"; "I think more about bad things that happened in the war"; and "Think more about using drugs." After some discussion, the patient decided that isolation was a "definitely have" problem for him and concluded that this behavior had significantly limited his functioning for many years.

The final module, Roadblocks (Session 6), focuses on how difficult it can be to consider changing one's own behaviors. Leaders discuss the concept of roadblocks as being things that make it difficult to even consider whether a behavior is problematic and in need of change. Common roadblocks include shame, fears, cognitive distortions, and inaccurate stereotypes about what it means to have a problem. In this context, veterans have often reported fears of being perceived as weak, or shame about the distress they have brought to loved ones. Cognitive distortions include all-or-nothing thinking such as "If I

admit to having one more problem, I will have to acknowledge being a complete failure." Stereotypes can cause problems such as reluctance to admit to an alcohol problem because of erroneous beliefs about what it means to be an alcoholic (e.g., the town drunk or homeless) or wanting to avoid being perceived as a "crazy Vietnam veteran." Patients often report that they want to avoid thinking that they had the same problems as a specific person in their past, such as a father with an alcohol problem or violent temper, or a family member who had been put into a mental hospital because of a "nervous breakdown." After the group generates a variety of possible roadblocks, participants are instructed to list on their worksheet only those that they feel apply to them. The collaborative process additionally provides a supportive context in which veterans can normalize and experience the universality of their feelings.

Program Evaluation

At the end of every group, each participant is asked to list on a special form any problems that he identified as "might have" during the course of that particular session. Also, patients are asked to report if they reclassified any behaviors previously identified as "might have" as "definitely a problem" or "definitely not a problem" at any time during that group session. Regular collection of these data allows group leaders and program evaluators to track the frequency and type of items about which patients show ambivalence regarding change. Perhaps more importantly, these data track individual and group changes in participants' beliefs about the need to change over the course of the group.

In addition to these session-by-session data, patients who complete all seven sessions of the group are asked to fill out a Consumer Satisfaction Survey (CSS). The CSS uses open-ended questions and Likert scale items to assess PTSD ME Group participants' understanding of group goals and process, their ratings of helpfulness of group modules and effectiveness of leaders and group process, and self-reported changes in acknowledgment of problem behaviors. These data can inform program staff about patients' acceptance and utilization of the group and allow patients to give feedback about their opinions and feelings about group participation. Social validity is an important issue (Foster & Mash, 1999) as group participants must perceive benefits to participation in order for a treatment to be implemented successfully, even when there are statistically measurable improvements in functioning.

Summary of Preliminary Findings

Findings from our uncontrolled evaluation study of the PTSD ME group are in press elsewhere (Murphy,

Cameron, et al., in press) and will be briefly summarized here. Data were collected over an 18-month period from 243 inpatients who attended the PTSD ME Group during their stay in a VA PTSD treatment program. Participants classified a wide range of categories of PTSD symptoms and related behaviors as "might have" problems, with the highest percentage of patients (48%) classifying anger as a "might have." Approximately one-third of the patients labeled isolation, depressive symptoms, trust, and health as a "might have," and about one-fourth reported conflict resolution, alcohol, communication, relationship/intimacy, restricted range of affect, and drugs as "might have." Other types of PTSD-related problems, for example, hypervigilance, were reported as "might have" by 15% to 21% of the patients. Reexperiencing problems were rarely identified as "might have."

With respect to changes in problem awareness and ambivalence during the course of the group, veterans on average reclassified approximately 40% of all items they initially listed as "might have" to either "definitely have" or "definitely don't have." For patients who classified various problems as "might have," by the end of their participation in the group significantly more veterans reclassified anger, isolation, anxiety, authority, guilt, emotional masking, relationship/intimacy, smoking, and trust problems as "definitely have" than "definitely don't have." Group participants reported high levels of satisfaction with all aspects of group content and process, and gave high ratings on helpfulness (Franklin et al., 1999). Although conclusive statements about the effectiveness of the group await controlled trials, these initial findings indicate that patients are responding to the group as predicted. Other findings have indicated that service-connected compensation and ethnicity were significantly related to patients' beliefs about the need to change (Murphy et al., 2000). Specifically, African Americans identified fewer problems that they were ambivalent about changing than Caucasian veterans, and having service-connected compensation was associated with lower frequency of reported changes in problem awareness or ambivalence.

We have also analyzed data addressing an important assumption underlying our methods: Specifically, the identification of a behavior, symptom, or coping style as a "might have" is associated with some likelihood that a problem actually exists. Preliminary findings indicated that each sample of patients who labeled a particular category of PTSD problems (e.g., anger, hypervigilance, isolation, restricted range of affect, etc.) as "might have" were above the cutoff for severe PTSD symptoms on the Intrusions, Avoidance, and Hyperarousal subscales of the PTSD Checklist (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993). Further, patients initially listing any particular problem as "might have" did not differ on the three

PCL subscales from patients who had listed the same problem as "definitely have." Similarly, Rosen et al. (2001) found a wide range of readiness to change even among PTSD patients with high levels of objectively assessed anger and alcohol problems.

Integrating the PTSD ME Group Into Programs

How would the PTSD ME Group, a brief therapy motivation intervention, best be implemented within a larger program? In our first major trial at the National Center for PTSD in Menlo Park, the PTSD ME Group was run concurrently with all other treatment components in a 60-day inpatient VA PTSD program. This approach had various pluses and minuses. One advantage, which initially seemed a disadvantage, was that the rolling admissions policy of the program created a mix of senior and new patients in all the groups, including the PTSD ME Group. This allowed the formation of a group culture, structured and unstructured, in which more senior peers acted as advisors and role models for newer members of the group. An important disadvantage of running the group over the same time period as other groups and activities is that patients may be learning coping skills that they may not be convinced they need. For example, given that almost 50% of patients may be ambivalent about anger being a problem for them, a number of participants in anger management groups may be less motivated to learn, practice, or use new ways of dealing with anger.

In contrast to the concurrent scheduling of the PTSD ME Group, as was implemented at Menlo Park, the PTSD ME Group has been run on a trial basis as part of the second of five phases of treatment in the PTSD Outpatient Clinic at the New Orleans VA Medical Center. Veterans entering into outpatient treatment begin with four weekly PTSD Education Group sessions designed to educate patients about the disorder and the therapeutic process. Patients then move to the PTSD ME Group and a case management group where they begin to identify problems, develop treatment plans, and discuss progress. The third phase focuses on coping skills such as stress management and cognitive restructuring. The fourth phase offers a developmental perspective, and the fifth phase focuses on relapse prevention. Patients move through the phases sequentially, although not necessarily at the same pace. The placement of the PTSD ME Group early in this sequence affords patients the opportunity to develop a new perspective on their own personal difficulties with a foundation of insight into PTSD and the process of treatment. Patients have an increased awareness of their potential difficulties and are better able to articulate these after the PTSD Education Group. Thus, the therapeutic process may be further enhanced by having the PTSD ME Group near the beginning of treatment,

when patients are developing goals and objectives. Treatment planning may be more relevant and focused, and treatment interventions offered in subsequent phases may be more effective.

A third method of integrating the PTSD ME Group into larger programs would be to offer a short, two- or three-session version of the group to patients who are considering whether or not to begin or continue treatment. Participation in a workshop-type format could help patients identify goals or problems they had not previously considered, or reconceptualize the nature of their presenting complaints. Patients could then make better decisions about the need to begin treatment or engage in additional treatment components.

Applying the PTSD ME Group to Nonveteran Populations

The PTSD ME Group has been primarily implemented with combat veterans, although we have run the group successfully with a small number of female veterans whose primary trauma involved sexual assault, sometimes with multiple incidents or childhood sexual abuse. There may be broader applicability of the group in that the PTSD symptoms and common comorbid problems targeted by the PTSD ME Group also exist in civilian trauma victims. Clinicians who consider using the PTSD ME Group with nonveteran PTSD populations must keep in mind that the group was designed to address patients experiencing a variety of problems, with the assumption that there will be variation in readiness to change across different PTSD symptoms and other problems. The PTSD ME Group, then, may not be appropriate for individuals with a recent, single-incident trauma, for example, with a circumscribed set of trauma symptoms and less general life dysfunction. Some of the PTSD ME Group techniques, however, may be helpful for such a patient who seems ambivalent or unaware of the need to change certain coping behaviors or beliefs related to the traumatic event. In the present climate of widespread anxiety following the September 11 terrorist attacks and anthrax scare (Murphy, Wismar, & Freeman, in press; Schuster et al., 2001), determining when fear-based behaviors are maladaptive can be a difficult task for anyone, but may be more so for PTSD patients and possibly mental health patients in general (Franklin, Young, & Zimmerman, 2002).

The motivational intervention discussed here is still under development, particularly because evidence from controlled studies regarding treatment effectiveness is lacking. Our ongoing research efforts, including the use of randomized controls, are aimed at testing the hypothesis that addition of a PTSD ME Group to a PTSD treatment program is associated with better learning, practice, and implementation of coping skills, which in turn should

predict better posttreatment functioning. Our goal here has been to offer a new approach for increasing the effectiveness of PTSD treatment that can be evaluated by clinicians and researchers as to its value, practicality, and long-term impact on patients' functioning. The outcome of our own and others' evaluation of the PTSD ME Group will determine the further development of this intervention.

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